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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2008-337
JOHN M. LEE 7910 S E 21st, Apt. D Portland, OR 97202	**ACCUSATION**
Registered Nurse License No. 575275	
Respondent.	

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about December 20, 2000, the Board issued Registered Nurse License Number 575275 to John M. Lee ("Respondent"). Respondent's registered nurse license expired on January 31, 2007.

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STATUTORY AND REGULATORY PROVISIONS

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
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> . . . .
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> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.
>
> (b) Procuring his or her certificate or license by fraud, misrepresentation, or mistake.
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> . . . .
>
> (e) Making or giving any false statement or information in connection with the application for issuance of a certificate or license . . .

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as

defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

7. Health and Safety Code section 11173 states, in pertinent part:

(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge . . .

8. California Code of Regulations, title 16, section ("Regulation") 1442 states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

CONTROLLED SUBSTANCES AT ISSUE

10. "Demerol," a brand of meperidine hydrochloride, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(17).

11. "Percocet," a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N).

12. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

13. "Morphine/morphine sulfate" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

14. "Vicodin," a combination drug containing 5 mg hydrocodone bitartrate, also known as dihydrocodeinone, and 500 mg acetaminophen per tablet, is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4).

FIRST CAUSE FOR DISCIPLINE

(Diversion of Controlled Substances)

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (a), in that in and between June and July 2006, while employed and on duty as a registered nurse at Scripps Green Hospital, La Jolla, California, Respondent obtained the controlled substances Demerol, Percocet, Dilaudid, and morphine by fraud, deceit, misrepresentation, or subterfuge, in violation of Health and Safety Code section 11173, subdivision (a), as follows: During the time period indicated above, Respondent removed varying quantities of Demerol, Percocet, Dilaudid, and morphine from the hospital's Pyxis MedStation[1] under the names of several different patients, when, in fact, there were no physician's orders authorizing the medications for the patients, the quantities of the medications removed were in excess of the doses ordered by the patients' physicians, or Respondent was not assigned to care for the patients. Further, Respondent failed to chart the administration or wastage of the controlled substances in the medication administration records ("MAR") and/or nursing notes, or made false statements or grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's records to conceal his diversion of the controlled substances, as more particularly set forth in paragraph 16 below. Further, in one instance, Respondent withdrew Dilaudid 2 mg/1 ml from the Pyxis under a patient's name when, in fact, that patient had been discharged from the hospital twelve hours earlier.

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1. The Pyxis Medication System is a computerized medication administration system designed to improve communication between hospital pharmacies and clinical settings, to decrease medication errors, and to improve patient safety. Individual licensed personnel are assigned a password to access the Pyxis by the hospital or health care agency Pharmacy Department. The system can thus identify users, the time they log in and out of the system, and their activities while logged in the system, enabling the hospital or health care agency to identify medication discrepancies.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

16. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that in and between June and July 2006, while employed and on duty as a registered nurse at Scripps Green Hospital, La Jolla, California, Respondent falsified, or made grossly incorrect, grossly inconsistent, or unintelligible entries in the hospital's records pertaining to the controlled substances Demerol, Percocet, Dilaudid, morphine, and Vicodin, as follows:

Patient 1:

a. On June 21, 2006, between 19:23 and 23:54 hours, Respondent withdrew a total of 500 mg of Demerol from the Pyxis under Patient 1's name, when, in fact, the physician's order called for the administration of Demerol 50 to 100 mg intramuscularly *every four hours* as needed for breakthrough pain. Further, Respondent failed to chart the administration or wastage of the Demerol in the patient's MAR or nursing notes and otherwise account for the disposition of the Demerol 500 mg.

Patient 2:

b. On June 21, 2006, at 23:16 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 2's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two tablets of Percocet. At 01:42 hours that same day, Respondent withdrew two additional tablets of Percocet from the Pyxis under Patient 2's name when, in fact, the physician's order called for the administration of one to two tablets of Percocet 5/325 mg *every three hours* for moderate to severe pain. Further, Respondent charted on the patient's MAR that he administered the Percocet to the patient at *01:30 hours.*

Patient 3:

c. On June 21, 2006, at 20:16 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 3's name, but failed to chart the administration or wastage of

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the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

d. On June 22, 2006, at 01:38 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 3's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

e. On June 22, 2006, at 04:49 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 3's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

Patient 4:

f. On June 22, 2006, at 06:45 hours, Respondent withdrew Demerol 25 mg/1 ml from the Pyxis under Patient 4's name, when, in fact, there was no physician's order authorizing the medication for the patient.[2] Further, Respondent failed to chart the administration or wastage of the Demerol in the patient's MAR or nursing notes and otherwise account for the disposition of the Demerol 25 mg/1 ml. In addition, Respondent was not assigned to care for the patient.

Patient 5:

g. On June 22, 2006, at 03:56 hours, Respondent withdrew one Dilaudid 2 mg/1 ml syringe from the Pyxis under Patient 5's name, when, in fact, there was no physician's order authorizing the medication for the patient. Further, the patient had been discharged from the hospital on June 21, 2006, at 15:15 hours. In addition, Respondent failed to chart the wastage of the Dilaudid in the patient's MAR and otherwise account for the disposition of the Dilaudid 2 mg/1 ml.

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2. Patient 4 had a physician's order while in the PACU for Demerol 15 mg by IV every 5 minutes for shivering. When the order was transferred to the patient's MAR, it was lined out, with a notation indicating "PACU order."

Patient 6:

h. On June 22, 2006, at 00:21 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 6's name, but charted on the patient's MAR that he administered the Percocet to the patient at *24:30 hours on June 21, 2006.* Further, Respondent documented the administration of the medication in the wrong column on the MAR.

i. On June 22, 2006, at 03:12 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 6's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

Patient 7:

j. On June 22, 2006, at 06:05 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 7's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg.

Patient 8:

k. On June 25, 2006, at 19:30 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 8's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg. Further, the nursing notes indicated that the patient was denying pain.

Patient 9:

l. On June 25, 2006, at 20:32 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 9's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg. Further, Respondent had not been assigned to care for the patient.

Patient 10:

m. On June 26, 2006, between 01:27 and 03:46 hours, Respondent withdrew a total of 6 mg of Dilaudid from the Pyxis under Patient 10's name, when, in fact, the physician's order called for the administration of Dilaudid *every three hours* (0.4 to 0.8 mg for moderate pain

and 0.8 to 1.6 mg for severe pain). Further, Respondent failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 6 mg.

Patient 11:

n. On June 27, 2006, at 19:56 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 11's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg. Further, Respondent was not assigned to care for the patient.

o. On July 2, 2006, at 19:27 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 11's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg. Further, Respondent was not assigned to care for the patient.

Patient 12:

p. On June 28, 2006, at 21:59 hours, Respondent withdrew PCA Dilaudid 10 mg/50 ml from the Pyxis under Patient 12's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the PCA Dilaudid 10 mg/50 ml. Further, Respondent was not assigned to care for the patient.

q. On June 28, 2006, at 23:16 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 12's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets. Further, Respondent was not assigned to care for the patient.

r. On June 29, 2006, at 03:43 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 12's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg. Further, Respondent was not assigned to care for the patient, as set forth in subparagraphs (p) and (q) above.

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Patient 13:

s. On June 28, 2006, at 02:05 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 13's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

t. On June 28, 2006, at 22:00 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 13's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

u. On June 29, 2006, at 02:07 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 13's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

v. On June 29, 2006, at 06:14 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 13's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

Patient 15:[3]

w. On June 28, 2006, at 20:45 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 15's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg.

x. On June 29, 2006, at 01:09 hours, Respondent withdrew two Percocet tablets from the Pyxis under Patient 15's name, but failed to chart the administration or wastage of the Percocet in the patient's MAR or nursing notes and otherwise account for the disposition of the two Percocet tablets.

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3. Patient number 14 is intentionally not included in this Accusation.

y. On June 29, 2006, at 03:03 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 15's name, but made an entry in the Pyxis that he administered Dilaudid 1.6 mg to the patient and wasted the remaining .4 mg at *05:05 hours,* as witnessed by another nurse. Further, Respondent failed to chart the administration or wastage of the Dilaudid 2 mg in the patient's MAR or nursing notes and/or otherwise account for the disposition of the Dilaudid 2 mg.

Patient 16:

z. On July 2, 2006, at 21:34 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 16's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg.

Patient 17:

aa. On July 2, 2006, at 20:04 hours, Respondent withdrew morphine 5 mg/ml from the Pyxis under Patient 17's name, charted in the MAR that he administered 2 mg of morphine to the patient at 20:00 hours, but failed to chart the wastage of the remaining 3 mg of morphine and/or otherwise account for the disposition of the 3 mg of morphine.

bb. On July 2, 2006, at 22:44 hours, Respondent withdrew two tablets of Vicodin from the Pyxis under Patient 17's name, but charted in the MAR that he administered two tablets of Vicodin to the patient at *20:00 hours.*

Patient 18:

cc. On July 2, 2006, at 19:30 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 18's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg.

dd. On July 3, 2006, at 07:15 hours, Respondent withdrew Dilaudid 2 mg from the Pyxis under Patient 18's name, but failed to chart the administration or wastage of the Dilaudid in the patient's MAR or nursing notes and otherwise account for the disposition of the Dilaudid 2 mg.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct. In and between June and July 2006, while employed and on duty as a registered nurse at Scripps Green Hospital, La Jolla, California, Respondent was guilty of gross negligence within the meaning of Regulation 1442, as follows: Respondent failed to conform to standards regarding the safe administration and documentation of controlled substances, including failing to account for controlled substances and failing to properly document the time the controlled substances were administered to patients, as set forth in paragraph 16 above.

FOURTH CAUSE FOR DISCIPLINE

(Disciplinary Action by the Board of Nursing for the State of Oregon)

18. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct. On or about October 20, 1998, pursuant to the Findings of Fact, Conclusions of Law, and Order in the disciplinary proceeding titled *In the Matter of: John Lee, RN*, Case No. 98-277, the Board of Nursing of the State of Oregon (hereinafter "Oregon Board") indefinitely suspended Respondent's license to practice registered nursing in that state based on the findings set forth below. A true and correct copy of the Findings of Fact, Conclusions of Law, and Order is attached hereto as Exhibit A and incorporated herein by reference.

a. Respondent was employed at Providence Medical Center from December 1995 to May 1998.

b. Respondent was suspected of diverting drugs from the workplace and was reported to the Oregon Board on April 24, 1998.

c. On May 1, 1998, during an interview at the Oregon Board's office, Respondent admitted to taking Demerol from the workplace for his personal use.

d. On May 1, 1998, Respondent signed a contract with the Board, agreeing to the terms and conditions of a program of supervision.

e. On May 26, 1998, Respondent had a chemical dependency evaluation, but did not follow through with treatment.

f. Respondent violated the terms of his contract with the Oregon Board's program of supervision.

g. Respondent has the disease of chemical dependency which remains untreated and negatively impacts his ability to safely practice nursing.

FIFTH CAUSE FOR DISCIPLINE

(Procuring License by Fraud, Misrepresentation, or Mistake)

19. On or about October 30, 2000, Respondent submitted an Application for Licensure by Examination to the Board. On October 24, 2000, Respondent certified under penalty of perjury that all information provided in connection with the application was true, correct, and complete. Respondent also acknowledged that providing false information or omitting required information is grounds for denial of licensure or license revocation in California.

20. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (b), in that Respondent procured his California registered nurse license by fraud, misrepresentation, or mistake, as follows:

a. Respondent certified under penalty of perjury on his California application for licensure that he had never previously taken an RN examination in another state or been licensed by examination as an RN in another state. In fact, Respondent was licensed as a registered nurse in the state of Oregon.

b. Respondent certified under penalty of perjury on his California application for licensure that he had never had disciplinary proceedings against any license as an RN or any health-care related license including revocation, suspension, probation, voluntary surrender, or any other proceeding. In fact, Respondent's license to practice registered nursing in the state of Oregon had been indefinitely suspended by the Oregon Board on October 20, 1998, as set forth in paragraph 18 above.

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SIXTH CAUSE FOR DISCIPLINE

(False Statements on Respondent's Application for Licensure)

21. Complainant incorporates by reference as though fully set forth herein the allegations contained in paragraphs 19 through 20 above.

22. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (e), in that Respondent made or gave false statements or information in connection with his application for issuance of his registered nurse license in California, as set forth in paragraph 20 above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 575275, issued to John M. Lee;

2. Ordering John M. Lee to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: June 4, 2008

Ruth M. Kane for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California

Complainant

03579-110-SD2007802527
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phd; 05/02/2008

EXHIBIT A

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

BEFORE THE BOARD OF NURSING
OF THE STATE OF OREGON

In the Matter of **JOHN LEE, RN** **License No. 94-000556**	)))))	**FINDINGS OF FACT** **CONCLUSIONS OF LAW** **AND ORDER** Case No. 98-277

This matter was considered at a meeting of the Board, in Portland, OR on September 9, 1998. The licensee, John Lee, did not appear personally. The purpose of the hearing was to determine whether the allegations contained in the Notice of Proposed Suspension of Registered Nurse license are true and whether John Lee's RN license to practice nursing in the State of Oregon should be indefinitely suspended.

FINDINGS OF FACT

Based on the evidence submitted through the Notice, testimony and the agency file in this case, the Board finds the following:

1.1 That John Lee is licensed to practice as a registered nurse in the State of Oregon.

1.2 That John Lee was employed at Providence Medical Center from December 1995 to May 1998.

1.3 That John Lee was suspected of diverting drugs from the workplace and was reported to the Board of Nursing on April 24, 1998.

1.4 That on May 1, 1998, during an interview at the Board office, John Lee admitted to taking Demerol from the workplace for his personal use.

1.5 That on May 1, 1998, he signed a contract with the Board agreeing to the terms and conditions of a program of supervision.

1.6 That on 5/26/98 John Lee had a chemical dependency evaluation but did not follow through with treatment.

1.7 That John Lee violated the terms of his contract with the Board's program of supervision.

1.8 That John Lee has the disease of chemical dependency which remains untreated and negatively impacts his ability to safely practice nursing.

1.9 That John Lee was sent a Notice of Proposed Suspension of Registered Nurse license by certified mail to his address of record on August 7, 1998.

1.10 That John Lee did not request a hearing within the twenty days allotted, thereby defaulting.

CONCLUSIONS OF LAW

Based on the foregoing findings of fact, the Board makes the following conclusions of law:

2.1 That the Board has jurisdiction over the licensee, John Lee, RN and over the subject matter of this proceeding.

2.2 That the use of controlled substances in a manner dangerous to the licensee and impairs the ability to safely practice nursing and is grounds for suspension of his license pursuant to ORS 678.111 (1)(e).

2.3 That failure to comply with the terms of participation in the voluntary monitoring program is grounds for disciplinary action pursuant to ORS 678.111 (1)(g), ORS 678.112 (6) and OAR 851-046-0020(7)(a).

ORDER

Based on the foregoing Findings of Fact, Conclusions of Law, and the Board being fully advised,

IT IS HEREBY ORDERED, that the the Registered Nurse license of John Lee be suspended.

Dated this 30th day of October, 1998

FOR THE BOARD OF NURSING
OF THE STATE OF OREGON

Pamela L. Townsend

PAMELA L. TOWNSEND, RN, MS
PRESIDENT

TO: JOHN LEE, RN

"You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board of Nursing within sixty (60) days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions of ORS 183.482.

As an alternative to filing a petition for reconsideration of this Order, you are entitled to a judicial review of this Order. Judicial review may be obtained by filing a petition for review within sixty (60) days from the service of this Order. Judicial review is pursuant to the provisions of ORS 183.482 to the Oregon Court of Appeals."